

STATE OF RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES
INDIVIDUAL PROVIDER ENROLLMENT FORM

Provider Number	Link ID	(Shaded Area for EDS use only)
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- | | |
|--|--------------------|
| 1. Provider Name _____ | Name Type _____ |
| 2. Business Name (if applicable) _____ | Census Tract _____ |
| 3. Business Type <input type="checkbox"/> Sole <input type="checkbox"/> Other
(Attach supporting documentation) | Cnty Code _____ |
| | Town Code _____ |
| | Location _____ |

4. Owner/Administrator, Managing Employee or Officer of Corporation Name **O**____ **A**____

5. Social Security Number _____ or FEIN _____

6. Service Location Address _____ City _____ State _____ Zip _____
Telephone () _____ Fax Number _____

7. Pay to Address _____ City _____ State _____ Zip _____

8. Mail to Address _____ City _____ State _____ Zip _____
Telephone () _____ Fax Number _____

9. Billing Service Address _____ City _____ State _____ Zip _____
Telephone () _____ Fax Number _____

10. Additional Practice Locations:

Street _____ City _____ State _____ Zip _____

Street _____ City _____ State _____ Zip _____

Street _____ City _____ State _____ Zip _____

11. Office Email Address _____ Contact Person _____

Name Type_____
Census Tract_____
Cnty Code_____
Town Code_____
Location_____

12. Medical License, License Chemical Dependency or Certification Number

13. Are you currently or have you ever been a provider under another medical specialty with Medical Assistance? ☐ YES ☐ NO

Dates: (Active and Inactive) _____

Status: _____

If Yes: What is your Rhode Island Medical Assistance ID Number/s _____

14. Is this application due to a merger, buy out or take over?

☐ YES

☐ NO

15. List any outstanding balance owed to Department of Human Services Medical Assistance by previous provider? _____

16. List your Medical Specialty _____ (see attached document)

17. National Provider Identifier (NPI) Number/s _____

18. Taxonomy Number/s _____

19. Medicare Number, if applicable (please also send CMS letter) _____

20. CLIA Number (Clinical Laboratory and Hospitals) _____

21. Number of Licensed Beds _____

Number of Swing Beds _____

22. EMC Biller ☐ YES

☐ NO

23. Fiscal Year End Date _____

24. Are you a Full or Part-time Salaried Employee of a Hospital or Institution?

☐ YES

☐ NO

If Yes, Name of Facility: _____

25. Enrollment effective date or date first served RI Medical Assistance (Medicaid) client.

_____ (Effective date is mandatory)

26. Exclusions under 42 CFR and/or sections 1128B and 1932(d)(1) of the Social Security Act: Prohibits you from 1) knowingly having a director, officer, partner, or person with a beneficial ownership of more than 5 percent of the entity's equity who is debarred, suspended, excluded, or has been convicted of a criminal offence related to that person's involvement in any Federal program, or 2) having an employment, consulting, or other agreement with an individual or entity for the provision of items and services that are significant and material to the entity's obligations under its contract with the State where the individual or entity is debarred, suspended, excluded, or convicted of a criminal offence related to that person's involvement in any Federal program.

This applies to myself and/or the entity(s): ☐ YES ☐ NO

If Yes, Please List (a) Date of Issuance, (b) Duration, (c) Name and address of person:

27. Document information on any debarment, suspension, exclusion, or criminal offence from federal program?

I certify that the foregoing information is true, accurate, and complete with the understanding that any falsification or concealment of a material fact may be prosecuted under Federal and State Laws.

Signature of Provider, Senior Partner, Chief Corporate Officer, or Authorized Agent

Title

Date

Full Name (printed)